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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 6/23/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Video Nystagmography and 72 Hour Ambulatory EEG monitoring (CPT 92546, 95951, 92540, 92537)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Neurology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The requested Video Nystagmography and 72 Hour Ambulatory EEG monitoring (CPT 92546, 95951, 92540, 92537) is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported injury on XX/XX/XX. The patient was hit in the head by a XX thrown by a XX. The diagnoses included post-concussion syndrome. Prior therapies included 10 sessions of physical therapy. The patient underwent a computed tomography (CT) of the brain on X/X/XX which revealed no evidence for cranial hemorrhage or skull fracture. The ventricular system appears normal in size and morphology. The neurology consultation dated X/X/XX revealed the chief complaint was the patient was status post physical assault with head injury, blurred vision, headaches, slurred speech, confusion, mental slowness, photo and

sono sensitivity, difficulty sleeping, nightmares, fear, startling, reactive depression, and anxiety. The physician indicated the history of the current illness included the patient was hit on the temporal area of her head. She did not lose consciousness nor fall to the ground. Since then, the patient had been having problems. The patient was seen at a local emergency room and had a CT scan which revealed no evidence of intracranial hemorrhage. The patient stated she was scared, even of driving. The current medications included Xulane and over the counter medications. The social history indicated the patient was not working. The physical examination revealed the patient walked into the examining room without any acute distress. It was noted the patient looked somewhat apprehensive and sad in thought. The patient was cooperative, though seemingly candid. There were no overt signs of neglect or magnification. The patient was congruous and goal oriented. The patient was alert and oriented times 3. Cognitive, intellectual, and behavioral functions were tested throughout the interview and examination. Also, "Mini-mental state examination (MMSE)" was provided and the patient scored 27 out of 30 with some errors on recall, orientation, and copying. The patient's AMD score was 100, consistent with severe depression. Speech and language were normal. Cranial nerve examination 2 through 12 was normal. The problem oriented neuromuscular examination revealed strength was 5/5 throughout the upper and lower extremities. Muscle stretch reflexes were symmetrically present throughout the biceps, triceps, and brachial radialis. The patient's reflexes were within normal limits. There was no clonus or Babinski. There were no long tracks lines. There was no pronation or drift. The finger to nose was normal. The Romberg sign was negative. Tandem gait was normal. Reverse tandem gait was normal. Sensory examination was normal for primary and secondary modalities. Spine and skull examination were normal. The impression included status post closed concussive traumatic brain injury, post-concussion syndrome, and post-traumatic stress disorder (PTSD). The treatment plan included amitriptyline, education, reassurance, hydrocodone for severe headaches, urine drug screen, and because of intermittent confusion and disorientation and having blacked out twice, and long term ambulatory video Electroencephalography (EEG) was recommended to rule out any paroxysmal cortical electrical activity (seizure). The proper neuropsychological assessment was to follow. The patient was to return with test results.

A request has been made for authorization of Video Nystagmography and 72 Hour Ambulatory EEG monitoring (CPT 92546, 95951, 92540, 92537). The Carrier denied the request citing a lack of medical necessity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines indicate electroencephalography is a well-established diagnostic procedure that monitors brainwave activity. The indication for an EEG include if there is failure to improve or additional deterioration following initial assessment and stabilization and EEG may aid in diagnostic evaluation. Additionally, the guidelines further indicate that video EEG is not recommended routinely for traumatic brain injury. It is recommended for diagnosing seizure disorders from epilepsy. The guidelines further indicate that vestibular studies are recommended to assess the function of the vestibular portion of the inner ear for patients who experience symptoms of vertigo, unsteadiness, dizziness, and other balance disorders. The clinical documentation submitted for review indicated the patient had blurred vision, headaches, slurred speech, confusion, mental slowness, photo and sono

sensitivity, difficulty sleeping, nightmares, fear, startling, and reactive depression and anxiety. However, there was no documentation indicating the patient had vertigo, unsteadiness, dizziness, or other balance disorders to support the necessity for vestibular studies. The physician requested electroencephalic and video recording. This testing is not appropriate for routine use. It is recommended for diagnosing seizure disorders from epilepsy. While the physician documentation indicated the requested testing was made to rule out any potential paroxysmal cortical electrical activity (seizure) due to the patient's intermittent confusion and disorientation and blacking out twice, there was no documentation the patient had a failure to improve or additional deterioration following the physician's initial assessment, as this was the initial assessment per the requesting physician. The physical examination failed to support the necessity for testing, as there were no abnormal findings noted. There were no exceptional factors to support the requested testing. The CT scan was negative. There was no lower level testing with abnormal results submitted for review to support the requested testing.

Therefore**,** I have determined the requested Video Nystagmography and 72 Hour Ambulatory EEG monitoring (CPT 92546, 95951, 92540, 92537) is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**